APPLICATION PART 2 TO THE GOLDEN STATE MUTUAL LIFE INSURANCE COMPANY

Proposed Insured ..... Birth Date:
First name Middle initial Last name Month Day Year

1. a. Name and address of your personal physician? _____
(If none, so state)
b. Date and reason last consulted? _____
c. What treatment was given or medication prescribed? _____

	Yes	No
2. Have you ever been treated for or ever had any known indication of:		
a. Disorder of eyes, ears, nose, or throat?	☐	☐
b. Dizziness, fainting, convulsions, headache; speech defect, paralysis or stroke; mental or nervous disorder?	☐	☐
c. Shortness of breath, persistent hoarseness or cough, blood spitting; bronchitis, pleurisy, asthma, emphysema, tuberculosis or chronic respiratory disorder?	☐	☐
d. Chest pain, palpitation, high blood pressure, rheumatic fever, heart murmur, heart attack or other disorder of the heart or blood vessels?	☐	☐
e. Jaundice, intestinal bleeding; ulcer, hernia, appendicitis, colitis, diverticulitis, hemorrhoids, recurrent indigestion, or other disorder of the stomach, intestines, liver or gallbladder?	☐	☐
f. Sugar, albumin, blood or pus in urine; venereal disease; stone or other disorder of kidney, bladder, prostate or reproductive organs?	☐	☐
g. Diabetes; thyroid or other endocrine disorders?	☐	☐
h. Neuritis, sciatica, rheumatism, arthritis, gout, or disorder of the muscles or bones, including the spine, back, or joints?	☐	☐
i. Deformity, lameness or amputation?	☐	☐
j. Disorder of skin, lymph glands, cyst, tumor, or cancer?	☐	☐
k. Allergies; anemia or other disorder of the blood?	☐	☐
l. Excessive use of alcohol, tobacco, or any habit-forming drugs?	☐	☐
m. Any mental or physical disorder not listed above?	☐	☐
3. Are you now under observation or taking treatment?	☐	☐
4. Have you had any change in weight in the past year?	☐	☐
5. *Other than above,* have you within the past 5 years:		
a. Had a checkup, consultation, illness, injury, surgery?	☐	☐
b. Been a patient in a hospital, clinic, sanatorium, or other medical facility?	☐	☐
c. Had electrocardiogram, X-ray, other diagnostic test?	☐	☐
d. Been advised to have any diagnostic test, hospitalization, or surgery which was not completed?	☐	☐
6. Have you ever had military service deferment, rejection or discharge because of a physical or mental condition?	☐	☐
7. Have you ever requested or received a pension, benefits, or payment because of an injury, sickness or disability?	☐	☐
8. Family History: Tuberculosis, diabetes, cancer, high blood pressure, heart or kidney disease, mental illness or suicide.	☐	☐

	Age if Living?	Cause of Death?	Age at Death?
Father			
Mother			
Brothers and Sisters			
No. Living			
No. Dead			

DETAILS of "Yes" answers. (**IDENTIFY QUESTION NUMBER, CIRCLE APPLICABLE ITEMS:** Include diagnoses, dates, duration and names and addresses of all attending physicians and medical facilities.)

9. Females only:	Yes	No
a. Have you ever had any disorder of menstruation, pregnancy or of the female organs or breasts?	☐	☐
b. Are you now pregnant?	☐	☐

I hereby declare that all of the statements and answers to the above questions are complete and true and include full particulars of each and every part of Questions 2 through 8 to which the answer is "Yes". I agree that the foregoing together with this declaration shall form a part, designated as Part 2, of the application for insurance.

Witness _____ M.D. X _____
Signature of Person Examined

Date _____ 19____

12149/RR

MEDICAL EXAMINER'S REPORT

10a. Height (In Shoes) ft. in.	Weight (Clothed) lbs.	Males Only: Chest (Full Inspiration) in.	Chest (Forced Expiration) in.	Abdomen, at Umbilicus in.

b. Did you weigh? ☐ Yes ☐ No Did you measure? ☐ Yes ☐ No
c. Is appearance unhealthy or older than stated age? ☐ Yes ☐ No

11. Blood Pressure (Record ALL readings)

Systolic			
Diastolic 4th phase			
Diastolic 5th phase			

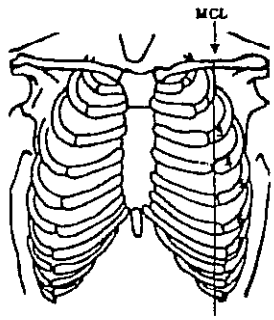
12. Pulse:	At Rest	After Exercise	3 Minutes Later
Rate			
Irregularities per min.			

13. Heart: Is there any:
Enlargement ☐ Yes ☐ No Dyspnea ☐ Yes ☐ No
Murmur(s) ☐ Yes ☐ No Edema ☐ Yes ☐ No
(describe below — if more than one, describe separately)

Location

Constant	☐	☐
Inconstant	☐	☐
Transmitted	☐	☐
Localized	☐	☐
Systolic	☐	☐
Presystolic	☐	☐
Diastolic	☐	☐
Soft (Gr. 1-2)	☐	☐
Mod. (Gr. 3-4)	☐	☐
Loud (Gr. 5-6)	☐	☐

Indicate:
Apex by X
Murmur area by ↻
Point of greatest intensity by O
Transmission by ◗



For comments and your impression?

After exercise:

Increased	☐	☐
Absent	☐	☐
Unchanged	☐	☐
Decreased	☐	☐

14. Is there on examination any abnormality of the following:
(Circle applicable items and give details.)

	Yes	No
(a) Eyes, ears, nose, mouth, pharynx? (If vision or hearing markedly impaired, indicate degree and correction.)	☐	☐
(b) Skin (incl. scars); lymph nodes; varicose veins or peripheral arteries?	☐	☐
(c) Nervous system (include reflexes, gait, paralysis)?	☐	☐
(d) Respiratory system?	☐	☐
(e) Abdomen (include scars)?	☐	☐
(f) Genitourinary system (include prostate)?	☐	☐
(g) Endocrine system (include thyroid and breasts)?	☐	☐
(h) Musculoskeletal system (include spine, joints, amputations, deformities)?	☐	☐
15. (a) Are there any hernias? ☐ Yes ☐ No (b) Any hemorrhoids?	☐	☐
16. Are you aware of additional medical history? (A confidential report may be sent to the Medical Director)	☐	☐

Details of "Yes" answers. (Identify item.)

Urinalysis: Specific Gravity	Albumin	Sugar

Is specimen being sent to Home Office? ☐ Yes ☐ No

Send Specimen To Home Office If:
(a) You found albumin or sugar in the urine; (b) there is a history of cardiovascular or urinary tract abnormality; (c) blood pressure is more than 140 systolic or more than 90 diastolic.

I certify that on the date shown I examined the person described herein whose answers to the questions on the reverse were recorded as given to me, and whose signature was written in my presence.

Date _____ 19____ _____ M.D. Examining Physician

TO — EXAMINING PHYSICIAN:

Date _____ 19____

This authorization must be signed and dated by the person examined.

Golden State Mutual Life Insurance Company is considering my Application for Insurance. I hereby authorize any licensed physician, medical practitioner, hospital, clinic, or other medical or medically related facility, insurance company, the Medical Information Bureau or other organization, institution or person, that has any records or knowledge of me or my health, to give to the Golden State Mutual Life Insurance Company any such information.

A photographic copy of this Authorization shall be as valid as the original.

X_____

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Signature of Proposed Insured

IMPORTANT — After the declarations have been completed and the examination has been made, this form (application Part 2) should be forwarded directly to the Home Office without delay. This should be done regardless of the condition of the person examined, the inability to complete the report in all details, or the request of anyone to the contrary.

PRINT

EXAMINING PHYSICIAN'S VOUCHERS (Do Not Detach)

It is important that this voucher be fully and properly completed

Name of Person Examined			Date of Examination
Examining Physician			Amount of Insurance
			$
Address of Examining Physician (No. & Street)	(City & State)	(Zip Code	Name of Agent Requesting Examination

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PRENOTICE

THIS PRENOTICE FORM MUST BE DETACHED AND GIVEN TO THE APPLICANT OR PROPOSED INSURED BEFORE THIS APPLICATION IS COMPLETED

Information regarding your insurability will be treated as confidential. The Golden State Mutual Life Insurance Company may, however, make a brief report thereon to the Medical Information Bureau, a non-profit membership organization of life insurance companies which operates an information exchange in behalf of its members. If you apply to another Bureau member company for life or heath insurance coverage, or a claim for benefits is submitted to such a company, the Bureau, upon request, will supply such company with the information it may have in its files.

Upon receipt of a request from you, the Bureau will arrange disclosure of any information it may have in your file. Medical information will be disclosed only to your attending physician. If you question the accuracy of the information in the Bureau's file, you may contact the Bureau and seek correction in accordance with the procedures set forth in the Federal Fair Credit Reporting Act. The address of the Bureau's information office is P.O. Box 105, Essex Station, Boston, Mass. 02112. Telephone number (617) 426-3660.

The Golden State Mutual Life Insurance Company may also release information in its file to other life insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted.

STATE OF TEXAS

NOTICE AND CONSENT FOR AIDS-RELATED BLOOD TESTING

GOLDEN STATE MUTUAL LIFE
HOME OFFICE: 1999 W. ADAMS BOULEVARD - LOS ANGELES, CALIFORNIA 90018

To evaluate your insurability, the Insurer named above (Golden State Mutual Life) has requested that you provide a sample of your blood for testing and analysis to determine the presence of human immunodeficiency virus (HIV) antibodies. By signing and dating this form you agree that this test may be done and that underwriting decisions will be based on the test result. A series of three tests will be performed by a licensed laboratory through a medically accepted procedure.

Pre-Testing Considerations — Many public health organizations have recommended that before taking an AIDS-related blood test a person seek counseling to become informed concerning the implications of such a test. You may wish to consider counseling, at your expense, prior to being tested.

Meaning of Positive Test Result — The test is not a test for AIDS. It is a test for antibodies to the HIV virus, the causative agent for AIDS, and shows whether you have been exposed to the virus. A positive test result does not mean that you have AIDS but that you are at significantly increased risk of developing problems with your immune system. The test for HIV antibodies is very sensitive. Errors are rare, but they do occur. Your private physician, a public health clinic, or an AIDS information organization in your city might provide you with further information on the medical implications of a positive test.

A positive HIV antibody test result will adversely affect your application for insurance. This means that your application may be declined, that an increased premium may be charged, or that other policy changes may be necessary.

Confidentiality of Test Result — All test results are required to be treated confidentially. They will be reported by the laboratory to the Insurer. The test result may be disclosed as required by law or may be disclosed to employees of the Insurer who have the responsibility to make underwriting decisions on behalf of the Insurer or to outside legal counsel who needs such information to effectively represent the Insurer in regard to your application. The result may be disclosed to a reinsurer, if the reinsurer is involved in the underwriting process. The test result may be released to an insurance medical information exchange under procedures that are designed to assure confidentiality, including the use of general codes that also cover results of tests for other diseases or conditions not related to AIDS, or for the preparation of statistical reports that do not disclose the identity of any particular person.

Notification of Test Result — If your test result is negative, no routine notification will be sent to you. If your test result is reported by the laboratory to the Insurer as being positive, you are entitled to that information if you so desire. Because a trained person should deliver that information so that you can understand clearly what the test result means, you are asked to list your private physcian so that the Insurer can have him or her tell you the test result and explain its meaning.

Name of physician for reporting a possible positive test result:

_____

Address _____

If you do not wish to know the result of the test, initial here: _____

In the event the test is positive and you are denied coverage because of that fact and you request the reason for the denial, the Insurer may require you to name a physician at that time in order to receive the information.

If you want to know the result of the test but do not at present have a private physician, initial here _____

The result will be sent to you at the address provided by registered mail with delivery restricted to you only.

If you desire the result to be mailed to some person other than yourself who is not a physician, print that person's name and address here:

_____

_____

The result will be sent to that person by registered mail with restricted delivery.

Consent — I have read and I understand this **Notice and Consent for AIDS-Related Blood Testing**. I voluntarily consent to the withdrawal of blood from me, the testing of that blood, and the disclosure of the test result as described above. I have read the information on this form about what a test result means and understand that I should contact a local AIDS service group or my private physician for further information and counseling if the test result is positive.

I understand that I have the right to request and receive a copy of this authorization. A photocopy of this form will be as valid as the original.

_____ _____

NAME OF PROPOSED INSURED SIGNATURE OF PROPOSED INSURED OR PARENT/GUARDIAN

_____ _____

ADDRESS DATE SIGNED